Appendix B

Suggested Legislation

Be it enacted by the People of the State of Maine as follows:

Sec. 1. **24-A MRSA c. 89** is enacted to read:

CHAPTER 89

MAINE HEALTH BENEFIT EXCHANGE ACT

§ 7001. *Short* title

This *chapter may* be known and cited as "the *Maine* Health Benefit Exchange Act."

§ 7002. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Board. *"Board" means the Board of Directors of the Maine Health Benefit Exchange established in section 7004.*

2. Educated health care consumer. "Educated health care consumer" means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical and scientific matters.

3. Exchange. "Exchange" means the *Maine Health Benefit Exchange* established *in section 7003*.

4. Executive Director. *"Executive Director" means the Executive Director of the Maine Health Benefit Exchange.*

5. Federal Affordable Care Act. *"Federal Affordable Care Act" has the meaning given to this term in section 14.*

Federally Recognized Indian Tribe. *"Federally Recognized Indian Tribe" means the Passamaquoddy Tribe, the Penobscot Nation, the Houlton Band of Maliseet Indians, the Aroostook Band of Micmacs, and any other Indian tribe of the State that is included on the list of Indian tribes most recently published by the Secretary of the United States Department of Interior pursuant to the Federally Recognized Indian Tribe List Act of 1994 (Pub. L. 103-454; 108 Stat. 4791, 4792).*

~~**The following definition of the Federal Act in the NAIC Model Act has been**~~

~~**modified to refer to the existing definition of PPACA in Title 24-A of the MRSA:**~~

~~**Federal Act.** "Federal Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or any regulations or guidance issued under, those Acts.~~

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~~6.~~7. **Health benefit plan.** "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

A. "Health benefit plan" does not include:

(1) Coverage only for accident or disability income insurance or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; or

(8) Insurance coverage *similar to any coverage listed in subparagraphs (1) to (7), as* specified in federal regulations issued pursuant to the *federal Health Insurance Portability and Accountability Act of 1996*, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

B. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited-scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(3) Limited benefits *similar to those listed in subparagraphs (1) and (2) as* specified in federal regulations issued pursuant to *the federal Health Insurance Portability and Accountability Act of 1996,* Public Law 104-191.

C. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

D. "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined under the *United States* Social Security Act, *section 1882(g)(1)*;

(2) Coverage supplemental to the coverage provided under *10 United States Code, chapter 55*; or

(3) Supplemental coverage *similar to coverage listed in subparagraphs (1) and (2)* provided under a group health plan.

~~*7.*~~ *8.* **Health carrier**. "Health carrier" or "carrier" means*:*

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32;

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; ~~*or*~~

E. An insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance as defined in section 707, subsection 1, paragraph C-1; or.

Any other entity providing a plan of health insurance, health benefits, or health services that may lawfully provide such benefits under state and federal law.

~~**The above subsection 7 modifies the following language in the NAIC Model Act to conform the definition of "health carrier" to Maine's statutory structure.**~~

~~"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident auto insurance company, a health maintenance organization, a nonprofit hospital and health services corporation, or any other entity providing a plan of health insurance, health benefits, or health services.~~

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~~8.~~9. ***Health insurance producer.*** *"Health insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate a health benefit plan.*

10. ***Large employer.*** *"Large employer" means an employer that employed an average of more than 100 employees during the preceding calendar year, provided that for plan years beginning before January 1, 2016, large employer means an employer that employed an average of 51 to 100 employees during the preceding calendar year.*

~~9.~~11. **Qualified dental plan.** "Qualified dental plan" means a limited-scope dental plan that has been certified in accordance with section *7009, subsection 5*.

~~10.~~12. **Qualified employer.** "Qualified employer" means a small employer that elects to make its full-time employees, and, at the option of the employer, some or all of its part-time employees, eligible for one or more qualified health plans offered through the SHOP Exchange, provided that the employer:

A. Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

B. Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

~~11.~~13. **Qualified health plan.** "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the *federal Affordable Care Act* and section *7009*.

~~12.~~14. **Qualified individual.** "Qualified individual" means an individual, including a minor, who:

A. Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

B. Resides in this State *within the meaning of the federal Affordable Care Act*;

C. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

D. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

~~13.~~15. **Secretary.** "Secretary" means the Secretary of the *United States* Department of Health and Human Services.

~~14.~~16. **SHOP exchange.** "SHOP Exchange" means the Small Business Health Options Program established pursuant to section *7008, subsection 2, paragraph I.*

~~15.~~17. **Small employer.** "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year, *provided that for plan years beginning before January 1, 2016, "small employer" means an employer that employed an average of not more than 50 employees during the preceding calendar year.* For purposes of this subsection:

A. All persons treated as a single employer under Section 414(b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as a single employer;

B. An employer and any predecessor employer shall be treated as a single employer;

C. Employees for purposes of determining the number of employees employed shall mean "eligible employees" as defined under section 2808-B, unless Federal law requires a different rule to be used to determine the number of employees and such Federal law preempts state law, in which case the number of employees shall be determined in accordance with Federal law;

D. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

E. An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, must continue to be treated as a small employer for purposes of this *chapter* as long as the employer continuously makes enrollment through the SHOP Exchange available to its employees.

§ 7003. ***Maine Health Benefit Exchange established; declaration of necessity***

1. ***Exchange established.*** The *Maine Health Benefit* Exchange is hereby established as *a governmental agency within the Department of Professional and Financial Regulation*.

2. ***Exchange Functions.*** The Exchange shall facilitate the purchase and sale of qualified health plans; provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and meet the requirements of this *chapter* and any regulations implemented under this *chapter*.

3. ***Contracting authority.*** The Exchange may contract with an eligible entity for any of its functions described in this *chapter*. *For the purposes of this subsection,* "eligible entity" includes, but is not limited to, the *MaineCare program* or *any* entity that has experience in individual and small group health insurance *or* benefit administration, or *has* other experience relevant to the responsibilities to be assumed by the entity, *except that an eligible entity does not include* a health carrier or an affiliate of a health carrier.

4. ***Intergovernmental Agreements and Coordination.*** The Exchange may enter into information-sharing agreements with federal and *other* state agencies and other state exchanges to carry out its responsibilities under this *chapter;* such agreements shall include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, *rules* and regulations.

§ 7004. [Board of Directors of Maine Health Benefit Exchange

The Exchange shall be governed by a Board of Directors, as established in this section.

1. ***Appointments.*** *The Board consists of 9 voting members and 2 ex officio, nonvoting members as follows:*

A. The 9 voting members of the Board are appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters, and confirmation by the Senate.

B. The Governor shall appoint the voting members as follows:

(1) At least one member representing insurers;

(2) At least one member representing health insurance producers;

(3) At least one member representing health care providers;

(4) At least one member representing large employers (as such term is defined as of the date of appointment);~~;~~

(5) *At least one member representing small employers (as such term is defined as of the date of appointment);~~:~~*

(6) *At least one member representing consumers~~individual health insurance purchasers~~; and*

(7) *At least one member representing federally recognized Indian tribes in the State.*

C. *The appointments of all voting members shall be made in accordance with state conflicts of interest laws. The appointments of voting members shall also be made in accordance with the federal Affordable Care Act so that a majority of the voting members of the Board do not have conflicts of interest, as defined in regulations implementing the federal Affordable Care Act.*

D. *The 2 ex officio, nonvoting members of the Board are:*

(1) *The Commissioner of Professional and Financial Regulation or the commissioner's designee; and*

(2) *The Commissioner of the Department of Health and Human Services or the commissioner's designee.*

2. Qualifications of voting members. *A majority of the voting members of the Board must have relevant experience in the following areas:*

A. *Health benefits administration;*

B. *Health care finance;*

C. *Health plan purchasing;*

D. *Health care delivery system administration;*

E. *Public health;*

F. *Health policy issues related to the small group and individual markets and the uninsured; or*

G. *Any additional areas of relevant experience identified in the federal Affordable Care Act.*

3. Terms of office. *Voting members of the Board serve 3-year terms. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2. A member may serve until a replacement is appointed and qualified. Of the initial members appointed to the Board, 3 members serve an initial term of one year, 3 members serve an initial term of 2 years, and 3 members serve an initial term of 3 years in order to achieve a staggered set of terms.*

Voting members may serve up to 2 consecutive terms, not including any initial term of less than 3 years.

4. Chair. *The Governor shall appoint one of the voting members of the Board as the chair of the Board.*

5. Quorum. *Five voting members of the Board constitute a quorum.*

6. Affirmative vote. *An affirmative vote of 5 members is required for any action taken by the Board.*

7. Compensation. *A member of the Board is entitled to compensation according to the provisions of Title 5, section 12004-G, subsection 14-H; a member must receive compensation whenever that member fulfills any Board duties in accordance with Board bylaws.*

8. Meetings. *The Board shall hold regular public governing meetings that are announced in advance. All meetings of the Board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.*

9. Governance. *The Board shall adopt rules in accordance with section 7008, subsection 4~~establish and make publicly available a set of guiding governance principles~~ that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest, including disclosure of financial interests by members of the Board, that meet the requirements of the federal Affordable Care Act and any applicable state law to the extent not inconsistent with the federal Affordable Care Act.]~~.~~*

§ 7005. [Executive Director

1. Appointed Position. *The Board shall appoint an Executive Director, who serves at the pleasure of the Board. The position of Executive Director is a major policy-influencing position as designated in Title 5, section 934~~934B~~.*

2. Duties of Executive Director. *The Executive Director shall:*

A. Serve as the liaison between the Board and the Exchange and serve as secretary and treasurer to the Board;

B. Manage the Exchange's programs and services;

C. Employ in accordance with Civil Service Law or contract on behalf of the Exchange for professional and nonprofessional personnel or services;

D. Coordinate the purchase and use of all equipment and supplies within the Exchange;

E. Approve all accounts for salaries, per diems, allowable expenses of the Exchange or of any employee or consultant and expenses incidental to the operation of the Exchange; and

F. Perform other duties prescribed by the Board to carry out the functions of this chapter. ~~.~~

§ 7006. Records

Except as provided in this section, information obtained by the Exchange under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. *Any personally identifiable financial information, supporting data or tax return of any person obtained by the Exchange under this chapter is confidential and not open to public inspection.*

2. Health information. *Health information obtained by the Exchange under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.*

~~**The above section 7006 is not in the NAIC Model Act. It is intended to conform the Exchange to Maine's statutory requirements related to public records and privacy of information.**~~

§ 7007. General Requirements

1. *Coverage.* The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

2. *Qualified health plan required.* The Exchange shall not make available any health benefit plan that is not a qualified health plan.

3. *Dental benefits.* The Exchange shall allow a health carrier to offer a plan that provides limited-scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the *federal Affordable Care Act*.

4. *No fee or penalty for termination of coverage.* Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

§ 7008. *Powers and* duties of the *Maine Health Benefit* Exchange

1. *Powers.* *Subject to any limitations contained in this chapter or in any other law, the Exchange shall have and may exercise all powers necessary or convenient to effect the*

purposes for which the Exchange is organized or to further the activities in which the Exchange may lawfully be engaged, including the establishment of the Exchange.

2. ***Duties.*** The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the *federal Affordable Care Act* and *pursuant to* section *7009*, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as provided under Section 1311(c)(6) of the *federal Affordable Care Act*;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the *federal Affordable Care Act* and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the *federal Affordable Care Act*;

F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under the *federal* Public Health Service Act, *42 United States Code*, Section 300gg-15 (2010);

G. In accordance with Section 1413 of the *federal Affordable Care Act*, inform individuals of eligibility requirements for the Medicaid program under the *United States* Social Security Act, Title XIX, or the *State* Children's Health Insurance Program under the *United States* Social Security Act, Title XXI, or *of eligibility requirements for* any applicable state or local public program and if, through screening of *an* application by the Exchange, the Exchange determines that *an* individual is eligible for any such program, enroll the individual in that program;

~~**The above paragraph G is modified from the NAIC Model Act language (reproduced below), which is confusing as written. The changes are intended to clarify the provision, not to make substantive changes.**~~

~~In accordance with Section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under the Social~~

~~Security Act, Title XIX, or the Children's Health Insurance Program (CHIP) under the Social Security Act, Title XXI, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;~~

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the *federal Affordable Care Act*;

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, enabl*ing* any qualified employer to specify a level of coverage that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage; *and determine whether to provide other ways for the SHOP Exchange to allow a qualified employer to offer one or more plans to its employees, such as allowing a qualified employer to select a single qualified health plan to offer to its employees*;

J. Subject to Section 1411 of the *federal Affordable Care Act*, *issue* a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that Section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

K. Transfer to the *United States* Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under paragraph J, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide the minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under Section 1411(b)(4) of the *federal Affordable Care Act* that *the individual* has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in paragraph K, *subparagraph* 2 who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the Exchange by the Secretary or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing or individual responsibility requirement exemptions;

N. Select entities*, through the award of grants or contracts,* to serve as navigators *who meet the requirements of* Section 1311(i) of the *federal Affordable Care Act*, standards developed by the Secretary, *and any registration or licensing requirements established by the Bureau of Insurance in consultation with the Exchange and the Department of Health and Human Services*; and award grants *or contracts* to enable navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the *federal Affordable Care Act*;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under federal Public Health Service Act, 42 United States Code,

Section 300gg-93 (2010) or any other appropriate state agency or agencies, for an enrollee with a grievance, complaint or question regarding a health benefit plan or coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of premium growth within the Exchange and outside the Exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Consult with stakeholders *regarding* carrying out the activities required under this *chapter*, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) *Representatives of* the *MaineCare program*;

(5) Advocates for enrolling hard-to-reach populations; and

(6) any other groups or representatives required by the federal Affordable Care Act;

The Board shall consult with an advisory committee, the members of which are appointed by the chief and council for each tribe of the federally recognized Indian tribes in the State. The Board may appoint other advisory committees that include stakeholders to advise and assist the Board in discharging its responsibilities under this chapter. Members of any advisory committee serve without compensation but may be reimbursed by the Exchange for necessary expenses while on official business of the advisory committee.

Q. Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the *Commissioner of Professional and Financial Regulation* a report concerning such accountings;

R. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the *federal Affordable Care Act*

and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(1) Investigate the affairs of the Exchange;

(2) Examine the properties and records of the Exchange; and

(3) Require periodic reports in relation to the activities undertaken by the Exchange;

S. In carrying out its activities under this *chapter*, *avoid* us*ing* any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications; and

T. Allow health insurance producers to enroll individuals and employers in any qualified health plans and to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through the Exchange.

3. Budget. *The Board or its designee shall submit a budget for the administration and operation of the Exchange to the Commissioner of Professional and Financial Regulation. The Board shall conduct an analysis of, and make recommendations to be included in the initial budget regarding, how the Exchange can be self-sustaining by 2015.*

4. *Rulemaking.* *The Exchange may adopt rules as necessary for the proper administration and enforcement of this chapter pursuant to the Maine Administrative Procedure Act. Unless otherwise specified or required by the Maine Administrative Procedure Act, rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this subsection shall be consistent~~may not conflict with or prevent the application of regulations promulgated by the Secretary under~~ the federal Affordable Care Act.*

5. Funding; Publication of costs

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this *chapter*. *Rules adopted pursuant to this paragraph are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.*

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on a *publicly accessible* website to educate consumers on such costs. This information must include information on money lost to waste, fraud and abuse.

6. Adjudications. *Any adjudications by the Exchange shall be conducted in accordance with the Maine Administrative Procedure Act and the federal Affordable Care Act.*

§ 7009. Health benefit plan certification

1. *Certification.* The Exchange may certify a health benefit plan as a qualified health plan if:

A. The *health benefit* plan provides the essential health benefits package described in Section 1302(a) of the *federal Affordable Care Act*, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection *5*, if:

(1) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(2) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric *dental* benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

B. *The forms for the health benefit plan* have been approved by the *superintendent in accordance with chapter 27*;

~~B.~~C. *The ~~and the~~ rates for the health benefit plan have been filed with the superintendent in accordance with chapter 33 or chapter 35, as applicable, the superintendent has completed any required review of the rates, and the superintendent has~~have~~ not ~~been~~ disapproved the rates [or determined the rates to be unreasonable].~~ by the superintendent.~~*

~~If the BOI disapproves a health plan's rates, it is not lawful for the plan to be offered in Maine. However, if the~~ BOI does not approve or disapprove rates in the small group market. BOI does determine whether a small group~~a~~ health plan's rates ~~but determines that they~~ are unreasonable, but this determination does not prevent a plan from being ~~because they are excessive or unfairly discriminatory, it is possible for the health plan to be lawfully~~ offered in Maine.

Question for the Advisory Committee: Should a determination by BOI that a small group health plan's rates are unreasonable preclude the plan from being certified in Maine as a QHP for the period of time during which the unreasonable rates are in effect?

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~~C.~~D. The *health benefit* plan provides at least a bronze level of coverage, as determined pursuant to section *7008, subsection 2, paragraph E* unless the

plan is certified as a qualified catastrophic plan, meets the requirements of the *federal Affordable Care Act* for catastrophic plans, and will be offered only to individuals eligible for catastrophic coverage;

~~D.~~E. The *health benefit* plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the *federal Affordable Care Act* and, if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the *federal Affordable Care Act*;

~~E.~~F. The health carrier offering the *health benefit* plan:

(1) Is licensed and in good standing to offer health insurance coverage in this State;

(2) Offers at least one qualified health plan in the silver level and at least one plan in the gold level *as described in Section 1302(d)(1)(B) and Section 1302(d)(1)(C) of the federal Affordable Care Act* through each component of the Exchange in which the carrier participates. *As used in this subparagraph,* "component" *means* the SHOP Exchange and the Exchange;

(3) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

(4) Does not charge any cancellation fees or penalties in violation of section *7007, subsection 4*; and

(5) Complies with the regulations developed by the Secretary under Section 1311(c) of the *federal Affordable Care Act* and such other requirements as the Exchange may establish; and

~~F.~~G. The *health benefit* plan meets the requirements of certification *established by regulation promulgated* by the Secretary under Section 1311(c) of the *federal Affordable Care Act and by the Exchange pursuant to section 7008, subsection 4* and, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance.

~~**The above paragraph F is modified from the NAIC Model Act language (reproduced below), which is confusing as written. The changes are intended to clarify the provision, not to make substantive changes.**~~

~~The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance;~~

~~**The following NAIC Model Act Paragraph G was removed because of the Advisory Committee's recommendation for the Exchange to be an open marketplace for plans and issuers that meet minimum certification requirements:**~~

~~G. The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.~~

2. ***Authority to exclude health benefit plans.*** The Exchange shall not exclude a health benefit plan:

A. On the basis that the *health benefit* plan is a fee-for-service plan;

B. Through the imposition of premium price controls by the Exchange; or

C. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances *in which* the Exchange determines the treatments are inappropriate or too costly.

3. ***Carrier requirements.*** The Exchange shall require each health carrier seeking certification of a *health benefit* plan as a qualified health plan to:

A. Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the *superintendent* under the *federal* Public Health Service Act, *42 United States Code, Section 300gg-94 (2010)* into consideration when determining whether to allow the carrier to make plans available through the Exchange;

B. Make available to the public and submit to the Exchange, the Secretary and the *superintendent* accurate and timely disclosure of the following:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost sharing and payments with respect to any out-of-network coverage;

(8) Information on enrollee and participant rights under Title I of the *federal Affordable Care Act*; and

(9) Other information as determined appropriate by the Secretary;

The information required in this paragraph *must* be provided in plain language, as that term is defined in Section 1311(e)(3)(B) of the *federal Affordable Care Act*; and

C. Permit *an* individual to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through a *publicly accessible* website and through other means for *an* individual without access to the Internet.

4. ***Application of licensing or solvency requirements.*** The Exchange *may* not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures fairness between or among health carriers participating in the Exchange. *The Exchange shall not be subject to state licensure or solvency requirements. No employee of the Exchange shall be permitted to engage in activities that require state licensure unless such employee is licensed to engage in such activities in accordance with state licensure requirements.*

5. ***Application to qualified dental plans.*** The provisions of this *chapter* that are applicable to qualified health plans also apply to the extent relevant to qualified dental plans except as modified in this subsection or by *rules* adopted by the Exchange.

A. The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

B. The *qualified dental* plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the *federal Affordable Care Act* and such other dental benefits as the Exchange or the Secretary may specify by *rule or* regulation.

C. Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also made available for purchase separately at the same price.

§ 7010. Relation to other laws

Nothing in this *chapter*, and no action taken by the Exchange pursuant to this *chapter*, shall be construed to preempt or supersede the authority of the *superintendent* to regulate the business of insurance within this State. Except as expressly provided to the contrary in this *chapter*, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and *rules* adopted and orders issued by the *superintendent*.

Sec. ***2 5 MRSA § 934, sub-§ 1, paragraph F*** *is enacted to read:*

F. Executive Director, Maine Health Benefit Exchange;

Sec. 2. 5 MRSA § 12004-G, sub-§ 14-H *is enacted to read:*

14-H.

Health Care, Board of Directors of the Maine Health Benefit Exchange, $100 per diem and expenses, 24-A MRSA § 7004.

Sec. 3. 10 MRSA § 8001 , sub-§39 *is enacted to read:*

39. The Maine Health Benefit Exchange

Sec. 4. Repeal of 24-A MRSA c. 89. *If the U.S. Supreme Court overturns all or part of the federal Affordable Care Act or the federal Affordable Care Act is repealed (in whole or in part) after the date of enactment of this chapter, within 60 days of such decision the Board shall recommend to the Legislature and the Governor whether to continue the Exchange. ~~and the Legislature shall consider such recommendation within 60 days without cloture.~~*